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Frailty Programme Reference Group ECHO Network

Session 2: Themes

10th August 2022
Welcome and Introductions

Caroline Nicholson
Professor of Palliative Care and Ageing
University of Surrey
## Agenda

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<td>Welcome and Introductions</td>
<td>Prof. Caroline Nicholson, Professor of Palliative Care and Ageing, University of Surrey</td>
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<td>15:40</td>
<td>Summary of Work So Far</td>
<td>Cat Sullivan, Senior Clinical and Quality Improvement Lead, Hospice UK</td>
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<td>16:00</td>
<td>Discussion of Themes 1-3</td>
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<td>Discussion of Evaluation</td>
<td>Prof. Max Watson, Project ECHO Programme Director, Hospice UK</td>
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<td>17:00</td>
<td>Close</td>
<td>Prof. Caroline Nicholson, Professor of Palliative Care and Ageing, University of Surrey</td>
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Safe Space Agreement
Summary of Work So Far

Cat Sullivan,
Senior Clinical and Quality Improvement Lead, Hospice UK
ECHO 1 – 11 July 2022

• ECHO 1: identify broad themes
• ECHO 2 10 August: consolidate priorities
• ECHO 3 sept : confirm project recommendations

Whole Systems Partnership:

• Heather and Peter and their team are external evaluation partners
• Independent ally, embedded and learning to the programme conclusion including the knowledge transfer and sustainability
• evaluate and capture evidence at local sites as they implement the ERG agreed best practice models
Extending Frailty Care Programme timeline

**Phase 1 - Planning**
- April 2022 – Sept 2022
  1. Engage Team & set up meetings
  2. Agree frailty attuned models for testing
  3. Agree criteria for grant applications

**Phase 2 - Delivery**
- Oct 2022 – Oct 2024
  1. Application selection process
  2. Set up Community of Practice
  3. Support hospices to test the models

**Phase 3 - Outcomes**
- Oct 2024 – April 2025
  1. Compile Evaluation Report
  2. Refine Resources
  3. Share learning

Support planning, testing and evaluation for sustainable improvement

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Headlines from the literature

1. different perspectives of frailty
2. workforce skills and knowledge
3. core capabilities
4. alternative approach to address uncertainly – multilevel, multifactorial – supporting community approaches and societal assets
5. systems perspective – the Acute frailty network – making frailty everybody’s business

**evidence biased toward clinical issues**

Introduction to Project ECHO
Arriving at the themes from the focus questions and the draft document

- We used the break out rooms and then distilled the Vevox list, and had open discussion time
- Initial meeting post the session
- Cat and Anita met
- Cat Anita and Max met
- Cat and Karl and Caroline
- Cat and Karl
- ECHO pre-meet

Focus Questions

1. What would you consider to be the main priorities in supporting hospices/palliative care working with older people who are living and dying with advancing frailty?

2. Are there examples of particular models or service that you have come across that work well to support specialist palliative care/hospice and other care providers to work together to support Older People with advancing frailty?

3. What is the biggest change you would like to see in hospices working with older people with frailty?
Expert Reference Group Themes

• 1. Living Well with Uncertainty
• 2. Compassionate Communities
• 3. Importance of Living Well NOW
• 4. Integrated Care
• 5. Dying Well with Frailty
• 6. Supporting domiciliary and residential services providing end of life care
1. Living Well with Uncertainty

People with frailty experience personal journeys, therefore it is a priority to support them in navigating uncertainty, problem solving and planning where appropriate.

Potential examples of projects could include:

- Identification of frailty, assessment, joint assessment, symptom management
- Education - upskilling of staff unfamiliar with frailty care
- Support for the patient in knowing who to call in varying circumstances e.g. single point of access/contact
2. Compassionate Communities

Supporting volunteers and communities in developing frailty awareness.

Potential examples of projects could include:

• Hospice supporting volunteers to help people with frailty in their community

• Social clubs

• “Strengths based” approaches – promoting independence and autonomy

• Combatting loneliness and isolation

• Improving contacts and relationships with old age services such as utilities/DIY services to support practical autonomy at home
3. Importance of Living Well NOW

Experience shows that many people do not care to focus on the future as they get older so we are keen to support people with frailty to live well “in the day”.

Potential examples of projects could include:

- Palliative rehabilitation
- Psychological, spiritual, social, peer support
- Support BEFORE and after crisis e.g. prevention of falls, polypharmacy, incontinence
- Morbidity prevention - to help people with frailty start the day positively by working in partnership with them to mitigate risk; for example by considering in advance interventions such as polypharmacy management and/or environmental factors such as those related to falls.
- Approaches to support people with frailty who do not wish to engage overtly with palliative care.
4. Integrated Care

Collaboration and joined up working are critical elements of the future plan to support our aging population and will reduce the risk of patients experiencing crises.

Potential examples of projects could include:

- Sharing information between hospice, hospital, community, care homes, voluntary sector and social networks including family
- Enhanced collaboration between palliative care, general practice, emergency care and elderly medicine clinicians
- Reducing unwarranted admissions to hospital e.g. preventing an elderly person with frailty being admitted to A&E unnecessarily where there is a palliative underlying concern
- Improving discharge from hospital
- Reducing points of access to make navigating the system easier
- Establishment of virtual wards
5. Dying Well with Frailty

Everybody is entitled in law to receive the best end of life care

Potential examples of projects could include:

• Demonstrating the place of hospice in supporting older people with frailty dying outside of hospice care

• Demonstrating psychological, spiritual, social and peer support

• Demonstrating how to enhance the care for those who have frailty that have complex palliative care needs

• Education - upskilling of staff unfamiliar with the care needs of people with frailty
6. Supporting domiciliary and residential services providing end of life care

Hospices are often working alongside community services and care homes caring for frail elderly people. We intend to encourage these relationships.

Potential examples of projects include:

- Supporting those with physical and cognitive frailty
- Provision of responsive and practical expertise when patients are approaching a clinical phase change or unpredicted or rapid deterioration that requires medical intervention – including potential 24 hr responses
- Supporting the learning for hospice staff and domiciliary/residential care staff around difficult conversations.
Gathering the Mind, Knowledge and Wisdom of the Expert Reference Group
1. Living well with uncertainty

- People with frailty experience personal journeys, therefore it is a priority to support them in navigating uncertainty, problem solving and planning where appropriate. Projects could include:
  - Identification of frailty, assessment, joint assessment, symptom management
  - Education - upskilling of staff unfamiliar with frailty care
  - Support for the patient in knowing who to call in varying circumstances e.g. single point of access/contact.

2. Compassionate Communities

- Supporting volunteers and communities in developing frailty awareness. Projects could include:
  - Hospice supporting volunteers to help people with frailty in their community
  - Social clubs
  - “Strengths based” approaches – promoting independence and autonomy
  - Combatting loneliness and isolation
  - Improving contacts and relationships with old age services such as utilities/ DIY services to support practical autonomy at home.

3. Living well NOW

- Experience shows that many people do not care to focus on the future as they get older, so we are keen to support people with frailty to live well “in the day”. Projects could include:
  - Palliative rehabilitation
  - Psychological, spiritual, social, peer support
  - Support BEFORE and after crisis e.g. prevention of falls, polypharmacy, incontinence
  - Morbidity prevention - to help people with frailty start the day positively. By working in partnership with them to mitigate risk; for example by considering in advance interventions such as polypharmacy and/or environmental factors such as those related to falls.
  - Approaches to support people with frailty who do not wish to engage overtly with palliative care.

Themes 1 – 3: What research, policy documents & practical examples are you aware of that could support the implementation of such frailty projects?
Gathering the Mind, Knowledge and Wisdom of the Expert Reference Group

1. Working together

2. Sharing your knowledge and recommendations re research evidence, policy alignments, and practical examples

via Discussion, Chat Box or email

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4. Integrated Care

- Collaboration and joined up working are critical elements of the future plan to support our aging population and will reduce the risk of patients experiencing crises. Potential examples of projects could include:
  - Sharing information between hospice; hospital; community; care homes, voluntary sector and social networks including family
  - Enhanced collaboration between palliative care, general practice, emergency care and elderly medicine clinicians
  - Reducing unwarranted admissions to hospital e.g. preventing an elderly person with frailty being admitted to A&E unnecessarily where there is a palliative underlying concern
  - Improving discharge from hospital
  - Reducing points of access to make navigating the system easier.
  - Establishment of virtual wards

5. Dying Well with Frailty

- Everybody is entitled in law to receive the best end of life care. Potential examples of projects could include:
  - Demonstrating the place of hospice in supporting older people with frailty dying outside of hospice care
  - Demonstrating psychological, spiritual, social and peer support
  - Demonstrating how to enhance the care for those who have frailty that have complex palliative care needs
  - Education - upskilling of staff unfamiliar with the care needs of people with frailty

4. Supporting domiciliary and residential services providing end of life care

Hospices are often working alongside community services and care homes caring for frail elderly people. We intend to encourage these relationships. Potential examples of projects include:

- Supporting those with physical and cognitive frailty
- Provision of responsive and practical expertise when patients are approaching a clinical phase change or unpredicted or rapid deterioration that requires medical intervention – including potential 24 hr responses
- Supporting the learning for hospice staff and domiciliary/residential care staff around difficult conversations.
Gathering the Mind, Knowledge and Wisdom of the Expert Reference Group

1. Working together

2. Sharing your knowledge and recommendations re research evidence, policy alignments, and practical examples via Discussion, Chat Box or email

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Evaluation

What evaluation tools/processes would you recommend using to evaluate these projects?
Gathering the Mind, Knowledge and Wisdom of the Expert Reference Group

1. Working together

2. Sharing your knowledge and recommendations re evaluation via Discussion, Chat Box or email
Close and Next Steps

Caroline Nicholson
Professor of Palliative Care and Ageing
University of Surrey
Final Session:

Topic: Review

Date: 26/09/2022

Time: 11:30 – 13:00

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